*The Commonwealth of Massachusetts*
*Department of Public Safety*
*State Boxing Commission*
*One Ashburton Place, Room 1301*
*Boston, Massachusetts 02108-1618*
*Phone (617) 727-3200*
*Fax (617) 727-5732*
*TTY (617) 727-0019*
*www.mass.gov/dps*

# APPLICATION FOR RINGSIDE PHYSICIAN'S LICENSE

(Please Type or Print Legibly With Ball Point Pen)
(Illegible or incomplete applications will not be accepted)

## I. BACKGROUND INFORMATION

NAME_____
First Middle initial Last

ADDRESS_____
Street City State Zip

DAYTIME TELEPHONE # (_____)_____ E-MAIL ADDRESS _____

DATE OF BIRTH ____/____/____ PLACE OF BIRTH _____

SOCIAL SECURITY # _____ OCCUPATION _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____
Street City State Zip

EMPLOYER'S TELEPHONE # (_____)_____

HAVE YOU EVER BEEN LICENSED AS A RINDSIDE PHYSICIAN IN ANOTHER STATE? _____
WHICH STATES? _____

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## II. THE FOLLOWING ITEMS MUST ACCOMPANY THIS APPLICATION (check box indicating compliance):

- ☐ $50 application fee
- ☐ two 1 inch by 1 inch photographs of the applicant's head (without headwear)
- ☐ copy of a government issued photo identification (e.g.- driver's license)
- ☐ copy of the applicant's physician's license

**III. ATTESTATION**

***I hereby attest, under the pains and penalties of perjury, that the information provided above is true and accurate to the best of my knowledge. Further, I certify that I have filed all required tax returns and paid all state taxes as required by law.***

_____ _____

Signature of applicant Date

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FOR OFFICIAL USE ONLY

DATE OF REVIEW: _____

APPROVED _____ DENIED _____
DF Yes ___ No ___
GL Yes ___ No ___
NM Yes ___ No ___

DATE LICENSE MAILED:

REASON FOR DENIAL: